

Manual Title	Chapter	Page
Dental Manual	V	
Chapter Subject	Page Revision Date	
Billing Instructions	6-20-2003	

CHAPTER V
BILLING INSTRUCTIONS

Manual Title	Chapter	Page
Dental Manual	V	i
Chapter Subject	Page Revision Date	
Billing Instructions	6-20-2003	

CHAPTER V

TABLE OF CONTENTS

	<u>Page</u>
Introduction	1
Mailing Instructions, Correspondence, and Provider Inquiries	1
Electronic Submission of Claims	2
Electronic Filing Requirements	2
Replenishment of Billing Materials	3
Timely Filing	3
Invoice Processing	5
Instructions for Completing the ADA (1994) Claim Form	6
Special Billing Instructions	11
Instructions for Completing the ADA (1994) Form as an Adjustment or Void Invoice	12
Preauthorization Requests	13
Preauthorization Approval Letters	14
Letter of Approval	14
Special Billing Procedures for Enrollees <u>Age 21</u> and Over	14
Instructions for Billing Medicare Coinsurance and Deductible	15
Instructions for Completion of the Department of Medical Assistance Services (Title XVIII) Medicare Deductible and Coinsurance Invoice, DMAS-30	16
Instructions for the Completion of the Department of Medical Assistance Services Medicare Deductible and Coinsurance (Title XVIII) Adjustment Invoice, DMAS-31 (Revised 6/96)	19
Remittance Voucher (Payment Voucher)	21

Manual Title	Chapter	Page
Dental Manual	V	ii
Chapter Subject	Page Revision Date	
Billing Instructions	6-20-2003	

ANSI X12N 835 Health Care Claim Payment Advice 22

Exhibits 23

Manual Title	Chapter	Page
Dental Manual	V	1
Chapter Subject	Page Revision Date	
Billing Instructions	6-20-2003	

CHAPTER V

BILLING INSTRUCTIONS

INTRODUCTION

This chapter provides guidance in completing the different DMAS Dental forms: the **ADA (1994) Claim Form**, is to be used for original claims and original preauthorization requests, the **DMAS-351** form is to be used to cancel or change an original preauthorization request, the **DMAS-361** form is to be used for attachments sent separately from the original preauthorization form (for example, dental models) and the **DMAS-3** form is to be used by electronic billers for attachments. **The DMAS-351, DMAS-361, DMAS-3 and the ADA (1994) Claim Form to be used for preauthorization requests will only be accepted on or after the date of implementation of the new MMIS claims system.** (See the “Exhibits” section at end of this chapter for a sample of the forms.)

The dental provider’s, the authorized agent’s signature, or the provider’s stamp or computer-printed name must appear on all forms above. The dental provider assumes sole responsibility for the completeness and accuracy of all information submitted for payment and preauthorization requests. The provider must be aware of the following statement, which appears on the ADA (1994) Claim Form:

“I hereby certify that the procedures as indicated by date have been completed and that the fees submitted are the actual fees I have charged and intend to collect for those procedures.”

MAILING INSTRUCTIONS, CORRESPONDENCE, AND PROVIDER INQUIRIES

The ADA (1994) Claim Form for claims should be mailed to:

Virginia Department of Medical Assistance Services
Dental
P.O. Box 27431
Richmond, VA 23261

and original preauthorization requests and any attached radiographs and the DMAS-351 should be mailed to:

Virginia Department of Medical Assistance Services
Dental
P.O. Box 25507
Richmond, VA 23261

The provider should be sure to include the correct amount of postage on the envelope. Failure to do so will result in the forms being returned to the provider for insufficient

Manual Title	Chapter	Page
Dental Manual	V	2
Chapter Subject	Page Revision Date	
Billing Instructions	6-20-2003	

postage.

Questions concerning billing problems, covered benefits, DMAS policy or remittances, and any miscellaneous correspondence should be mailed to:

Virginia Department of Medical Assistance Services
Customer Services Unit
600 East Broad Street, Suite 1300
Richmond, Virginia 23219

Telephone inquiries should be directed to the DMAS HELPLINE number:

(804) 786-6273	Richmond Area and out-of-state
1-800-552-8627	In-state toll-free

Questions concerning recipient eligibility should be directed to the Audio Response System (ARS) at the following numbers:

1-800-884-9730	All other areas
(804) 965-9732	Richmond and surrounding counties
(804) 965-9733	Richmond and surrounding counties

ELECTRONIC SUBMISSION OF CLAIMS

Providers may submit claims electronically. Electronic Data Interchange (EDI) is a fast and effective way to submit Medicaid Claims. Claims will be processed faster and more accurately because electronic claims are entered in to the claims processing system directly. For more information contact our fiscal agent, First Health:

Phone: (888) 829-5373 and choose Option 2 (EDI),

Fax number: (804)-273-6797

First Health's website: <http://virginia.fhsc.com>,

Mailing address:

EDI Coordinator-Virginia Operations
First Health Services Corporation
4300 Cox Road
Richmond, Virginia 23060

ELECTRONIC FILING REQUIREMENTS

The Virginia MMIS is HIPAA-compliant and, therefore, supports all electronic filing requirements and code sets mandated by the legislation. Accordingly, National Standard Formats (NSF) for Dental electronic claims submissions will not be accepted after June 15, 2003, and all local service codes will be ended for claims with dates of service after October 15, 2003. All claims submitted with dates of service after October 15, 2003 will be denied if local codes are used.

Manual Title	Chapter	Page
Dental Manual	V	3
Chapter Subject	Page Revision Date	
Billing Instructions	6-20-2003	

The Virginia MMIS will accommodate the following EDI transactions according to the specifications published in the ASC X12 Implementation Guides version 4010A1.

- **837D for submission of Dental claims (Proprietary formats for electronic submission of claims will no longer be accepted for Dental claims. Beginning June 16, 2003, to submit dental claims electronically, use the 4010 version of the 837 D.)**
- 276 & 277 for claims status inquiry and response.
- 835 for remittance advice information for adjudicated claims (paid and denied).
- 270 & 271 for eligibility inquiry and response.
- 278 for prior authorization request and response.

Although not mandated by HIPAA, DMAS has opted to produce an Unsolicited 277 transaction to report information on pended claims.

If you are interested in receiving more information about utilizing any of the above electronic transactions, your office or vendor can obtain the necessary information at our fiscal agent's website: <http://virginia.fhsc.com>.

REPLENISHMENT OF BILLING MATERIALS

As a general rule, DMAS will no longer provide a supply of agency forms which can be downloaded from the DMAS website (www.dmas.state.va.us). To access the forms, click on the "Search Forms" function on the left-hand side of the DMAS home page and select "provider" to access provider forms. Then you may either search by form name or number. If you do not have Internet access, you may request a form for copying by calling the DMAS form order desk at 1-804-780-0076.

TIMELY FILING

The Medical Assistance Program regulations require the prompt submission of all claims. Virginia Medicaid is mandated by federal regulations to require the initial submission of **all** claims (including accident cases) within 12 months from the date of service. Providers are encouraged to submit billings within 30 days from the last date of service. Federal financial participation is not available for claims which **are not** submitted within 12 months from the date of the service. If billing electronically and timely filing must be waived, submit the **DMAS-3** form with the appropriate attachments. (The **DMAS-3** form is to be used by electronic billers for attachments. See the "Exhibits" section.) Medicaid is not authorized to make payment on these late claims, except under the following conditions:

- **Retroactive Eligibility** - Medicaid eligibility can begin as early as the first day of the third month prior to the month of application for benefits. All eligibility requirements must be met within that time period. Unpaid bills for that period can be billed to Medicaid the same as for any other service. If the enrollment is not accomplished timely, billing will be handled in the same manner as for

Manual Title	Chapter	Page
Dental Manual	V	4
Chapter Subject	Page Revision Date	
Billing Instructions	6-20-2003	

delayed eligibility.

- **Delayed Eligibility** - Medicaid may make payment for services billed more than 12 months from the date of service in certain circumstances. Medicaid denials may be overturned or other actions may cause eligibility to be established for a prior period. Medicaid may make payment for dates of service more than 12 months in the past when the claims are for a recipient whose eligibility has been delayed. Providers who have rendered care for a period of delayed eligibility will be notified by a copy of a letter from the local department of social services which specifies the delay has occurred, the Medicaid claim number, and the time span for which eligibility has been granted.

The provider must submit a claim on the appropriate ADA (1994) Claim Form within 12 months from the date of the notification of the delayed eligibility. A copy of the dated letter from the local department of social services indicating the delayed claim information must be attached to the claim.

Users of the ADA (1994) Claim Form must request individual consideration for any claim filed over one year from the date of service explaining the reason for the late billing in block 38.

- Explain the reason for the late submission in the 'Remarks' section of the ADA (1994) Claim Form and submit the claim in the usual manner to:

Virginia Department of Medical Assistance Services
Dental
P. O. Box 27431
Richmond, Virginia 23261-7431

- **Accident Cases** - The provider may either bill Medicaid or wait for a settlement from the responsible liable third party in accident cases. However, all claims for services in accident cases must be billed to Medicaid **within 12 months** from the date of the service. If the provider waits for the settlement before billing Medicaid and the wait extends beyond 12 months from the date of the service, no reimbursement can be made by Medicaid as the time limit for filing the claim has expired.
- **Other Primary Insurance** - The provider should bill other insurance as primary. However, all claims for services **must be billed to Medicaid within 12 months from the date of service**. If the provider waits for payment before billing Medicaid, and the wait extends beyond 12 months from the date of service, no reimbursement can be made by Medicaid, as the time limit for filing the claim has expired. If payment is made from the primary insurance carrier after a payment from Medicaid has been made, an adjustment or void should be filed at that time.

Manual Title	Chapter	Page
Dental Manual	V	5
Chapter Subject	Page Revision Date	
Billing Instructions	6-20-2003	

INVOICE PROCESSING

The Medicaid invoice processing system utilizes a sophisticated electronic system to process Medicaid claims. Once a claim has been received, imaged, assigned a cross reference number, and entered into the system, it is placed in one of the following categories:

- Turnaround Document Letter - "TAD" - If lines on the ADA (1994) Claim Form were completed improperly, a computer-generated letter (TAD) is sent to the provider to correct the error. The TAD should be returned to FHS. The claim will be denied if the TAD is not received in the system within 21 days. **Only requested information should be returned.** Additional information will not be considered and may cause the claim to deny in error.
- Remittance Voucher
 - **Approval** - Payment is approved or placed in a pended status for manual adjudication (the provider must not resubmit).
 - **Denied** - Payment cannot be approved because of the reason stated on the remittance voucher.
- No Response - If one of the above responses has not been received within 30 days, the provider should assume non-delivery and rebill using a new invoice form. **The provider's failure to follow up on these situations does not warrant individual or additional consideration for late billing.**

Manual Title	Chapter	Page
Dental Manual	V	6
Chapter Subject	Page Revision Date	
Billing Instructions	6-20-2003	

INSTRUCTIONS FOR COMPLETING THE ADA (1994) CLAIM FORM

The instructions apply to claim submissions and preauthorization requests. Unless specified otherwise, the “Required” locators will apply to both claims and preauthorization (PA) requests. The ADA (1994) Claim Form will be used to request PA on the date of implementation of the new MMIS claims system. Pay special attention to the locators marked with an asterisk (*). These locators are being used by the Department of Medical Assistance Services (DMAS) for information that is different than the original intent by the American Dental Association.

Locator	Description	
1	Required (claims and PA)	Provider ID # -- Enter the Medicaid provider ID number of the billing provider.
2	Required (claims)	Prior Authorization # -- Enter the PA number for approved requests for claims processing.
	Required (claims and PA)	Patient ID # -- Enter the 12-digit Medicaid ID number.
*3	Required (claims and PA)	Carrier Name and Address -- This block is used for the transmission code. Enter 180 for PA request, 181 for Original Claim, 182 for Adjustment, or 184 for Void.
4	Required (claims and PA)	Patient’s Name – Enter the last name and first name of the Enrollee.
5	Not Required	Relationship to Employee
6	Optional (PA only)	Sex
*7	Conditional (claims only)	Patient’s Birth Date -- If the transmission code entered in Block 3 is 182 or 184, enter the 4-digit code for the reason for the adjustment or void (see additional instructions included in this chapter). Digit 1 and 2 should be placed in MM, digit 3 in DD, and digit 4 in YYYY.
	REQUIRED (PA only)	Patient’s Birth Date – Enrollee’s date of birth.
*8	Conditional (claims only)	If full time student -- If the transmission code entered in Block 3 is 182 or 184, enter the ICN number (found on the

Manual Title	Chapter	Page
Dental Manual	V	7
Chapter Subject	Page Revision Date	
Billing Instructions	6-20-2003	

Locator	Description
	remittance voucher) of the claim that is being adjusted or voided.
9 Optional (PA only)	Employee/subscriber name and mailing address.
10 Optional (PA only)	Employee/subscriber dental plan I.D. number -- If each patient account is maintained by a number or an office location, it may be entered in this block (maximum of 17 digits and/or letters). This number will appear on the Remittance Voucher to assist in identifying the account.
11 Optional (PA only)	Employee/subscriber birthdate
12 Optional (PA only)	Employer (company) name and address
13 Optional (PA only)	Group number
14 Conditional (PA only)	Is patient covered by another dental plan/medical plan
15a Conditional (PA only)	Name and address of carrier(s)
15b Conditional (PA only)	Group no(s)
16 Optional (PA only)	Name and address of other employer
17a Optional (PA only)	Employee/subscriber name (if different from patient's)
17b Optional (PA only)	Employee/subscriber dental plan I.D. number
18 Optional (PA only)	Relationship to patient
19 Not Required	Signature of patient
20 Not Required	Signature of employee/subscriber

Manual Title	Chapter	Page
Dental Manual	V	8
Chapter Subject	Page Revision Date	
Billing Instructions	6-20-2003	

Locator	Description	
21	Required (PA only)	Name of billing dentist
22	Optional (PA only)	Address where payment should be remitted
23	Optional (PA only)	City, State, Zip
24	Optional (PA only)	Dentist Soc. Sec. or T.I.N.
25	Optional (PA only)	Dentist license no.
26	Required (PA only)	Dentist phone no.
27	Optional (PA only)	First visit date current series
28	Optional (PA only)	Place of treatment
29	Conditional (claims and PA)	Radiographs or models included?
30	Conditional (claims and PA)	Is treatment result of occupational illness or injury? -- When the patient has other dental coverage, Medicaid is a last-pay program. Therefore, if treatment is required due to an accident, check yes in this block and note under the Remarks section all available information concerning the accident and the possibility of other insurance carriers. Leave blank if the treatment is not the result of an accident.
31	Conditional (claims and PA)	Is treatment result of auto accident? -- See detailed instructions for Block 30.
32	Conditional (claims and PA)	Other accident? -- See detailed instructions for Block 30.
33	Not Required (claims only)	If prosthesis, is this partial treatment?

Manual Title	Chapter	Page
Dental Manual	V	9
Chapter Subject	Page Revision Date	
Billing Instructions	6-20-2003	

Locator	Description	
	Conditional (PA only)	If prosthesis, is this partial treatment?
34	Conditional (PA only)	Date of prior placement
35	Required (PA only)	Is treatment for orthodontics?
36	Conditional (PA only)	Identify Missing Teeth
*37	Required (claims and PA)	<p>Tooth # or letter -- Enter the tooth # (if applicable). Refer to the Medicaid Dental Manual for the valid tooth codes.</p> <p>Surface -- Enter the surface of the tooth (if applicable). Refer to the Medicaid <i>Dental Manual</i> for the valid surface codes.</p> <p>Description of service – Not required.</p> <p>Date Service Performed (month/day/year) -- Enter the date of service/request for each individual line item. Do not leave this block blank.</p> <p>Procedure number -- Enter the number of units and the 5-digit dental procedure code performed. (Use the codes listed in Appendices B and C of the <i>Dental Manual</i>.) See special billing instructions for Dental Clinics associated with Federally Qualified Health Centers and Rural Health Clinics.</p> <p>Fee -- Enter your usual and customary charge for the procedure performed. Not required for PA requests.</p> <p>For administrative use only -- If an Enrollee has other dental coverage (e.g., CHAMPUS, school insurance, etc.) and, this insurance has paid a portion of the care, enter any payment from a primary carrier other than Medicare. Include a copy of the explanation of payments from other carriers with the invoice. For billing Medicare deductible and coinsurance, use the DMAS-30 (Title XVIII) invoice.</p>
38	Conditional (claims and PA)	Remarks for unusual services -- If treatment is related to an accident, provide any additional information in the block. See the instructions for Blocks 30-32 above. Please note that any

Manual Title	Chapter	Page
Dental Manual	V	10
Chapter Subject	Page Revision Date	
Billing Instructions	6-20-2003	

Locator

Description

information that is placed in this block or any document that is attached to the claim will cause all lines of the claim to pend for manual review to justify a claim even if the “Remarks” or the attachment only applies to one line of the claim. Therefore, if you have multiple lines of a claim to complete and only one line requires that you provide DMAS with additional information (either in “Remarks” or with an attachment), you should bill the one line on a separate claim form so that all lines of your claim will not pend unnecessarily and cause a delay in reimbursement.

Use this block to provide supporting documentation for PA requests. Claims for non-authorized, urgent, or non-urgent services requiring PA, enter “IC” for individual consideration in this block along with a written narrative. Refer to Chapter IV for more detail.

39	Required (claims and PA)	Signature of dentist, license number and date
40	Not Required	Address where treatment was performed
41	Not Required	Total Fee Charged
42	Not Required	Payment by other plan

Manual Title	Chapter	Page
Dental Manual	V	11
Chapter Subject	Page Revision Date	
Billing Instructions	6-20-2003	

SPECIAL BILLING INSTRUCTIONS

Dental Clinics Associated with Federally Qualified Health Centers and Rural Health Clinics

For Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs) that have dental clinics associated with them, the local code 00088 will no longer be valid for claims with dates of service on or after October 16, 2003. You will need to bill Medicaid using one of the standard Current Dental Terminology (CDT-4) codes (either D0120 or D0150) for dental examinations. You will continue to bill the dental visit “encounter” on the American Dental Association claim form (ADA (1994) Claim Form).

Below is the crosswalk from the old to new billing code for dental clinics associated with FQHCs/RHCs:

<u>Old Code</u>	<u>New Codes</u>
00088	D0120, D0150

Manual Title	Chapter	Page
Dental Manual	V	12
Chapter Subject	Page Revision Date	
Billing Instructions	6-20-2003	

INSTRUCTIONS FOR COMPLETING THE ADA (1994) FORM AS AN ADJUSTMENT OR VOID INVOICE

The ADA (1994) Claim Form can be used for adjusting or voiding payments previously approved on Remittance Vouchers. Only one line can be billed on an ADA (1994) form used for adjustment or voids. Continue to follow the instructions in the *Dental Manual* for submitting adjustments and voids. The only information that has changed is listed below:

Locator	Description
3	Carrier Name and Address -- Enter code 182 to indicate adjustment or 184 to indicate a void.
7	<p>Patient's Birthdate -- Enter the 4-digit code below that identifies the reason for the adjustment or void. Enter the first two digits of the code in the MM, the third digit in DD and the fourth digit in CCYY. NOTE: the 4-digit code can only be used after the implementation of the new MMIS claims system.</p> <p><u>Adjustment codes:</u> 1028 - correcting procedure/service code 1030 - correcting charge 1038 - correcting tooth code 1039 - correcting site code 1053 - adjustment is in misc. reason category</p> <p><u>Void codes:</u> 1044 - provider ID correction 1045 - recipient ID correction 1052 - void is in misc. reason category</p>
8	If Full Time Student -- Enter the ICN number of the claim that is being adjusted or voided.

Manual Title	Chapter	Page
Dental Manual	V	13
Chapter Subject	Page Revision Date	
Billing Instructions	6-20-2003	

Preauthorization Requests

The Department of Medical Assistance Services (DMAS) uses the services of a private contractor, WVMI, to preauthorize dental services for recipients under age 21. The preauthorization request submitted on the ADA (1994) Claim Form must **not** be used to submit charges for payment. To submit a dental preauthorization request, mail the ADA (1994) Claim Form and any attachments to FIRST HEALTH Services Corporation, the fiscal agent for DMAS:

Virginia Department of Medical Assistance Services
Dental
P.O. Box 25507
Richmond, VA 23261

FIRST HEALTH Services Corporation will data enter the paper request for preauthorization and forward it and any attachments to WVMI. However, the attachments which relate to orthodontic cases (i.e., orthodontic models and/or x-rays), must be submitted by the provider directly to WVMI. Please attach a completed **DMAS-361** form. The address is:

WVMI
6802 Paragon Place, Suite 410
Richmond, VA 23230

It is imperative that any materials submitted to WVMI be well-labeled with the recipient's name and Medicaid number, the provider's name and Medicaid number directly attached to the individual dental materials along with the **DMAS-361** form to ensure a correct match to the PA request.

The turnaround time for providers receiving a response to a paper preauthorization request is about two weeks from the date received by WVMI. For questions regarding any dental preauthorizations, contact WVMI at the following telephone numbers:

(804) 648-3159	Richmond Area
(800) 299-9864	All Other Areas

Use the WVMI telephone numbers only for dental preauthorization questions. Contact the HELPLINE with all other questions.

If preauthorization is denied by the WVMI dental consultants and the provider wants a reconsideration of the denial, the provider must submit a letter to the WVMI Preauthorization Supervisor requesting reconsideration within 30 days of the written notification of denial of the reconsideration. After completion of the reconsideration process, the denial of preauthorization for services not yet rendered may be appealed in writing by the Medicaid recipient within 30 days of the written notification of denial to:

Manual Title	Chapter	Page
Dental Manual	V	14
Chapter Subject	Page Revision Date	
Billing Instructions	6-20-2003	

Director, Appeals Division
Department of Medical Assistance Services
600 East Broad Street, Suite 1300
Richmond, Virginia 23219

NOTE: For a true emergency/urgent situation **or** when planned non-urgent services requiring prior approval are performed for enrollees **under age 21**, you may bill using the ADA (1994) Claim Form to request individual consideration (IC) and explain the situation in the Remarks section in block 38. (This option does not apply to full banded orthodontics.) Attach all required clinical documentation and radiographs to support the claim and mail to:

Virginia Department of Medical Assistance Services
Dental
P.O. Box 27431
Richmond, Virginia 23261-7431

PREAUTHORIZATION APPROVAL LETTERS

Letter of Approval

After a preauthorization request (ADA (1994) Claim Form) has been approved, the DMAS preauthorization contractor, WVMi, will send a letter of approval, which will indicate the authorization number to be used for billing on the ADA (1994) Claim Form. **Only one PA number will be issued for all approved lines per PA request.** The provider must place the authorization number in Block 2 (PriorAuthorization #) of the ADA (1994) Claim Form when billing. Information on the ADA (1994) Claim Form (the provider number, enrollee number, tooth code, surface code, procedure code, and number of procedures) must agree exactly with those on the approved dental preauthorization. **If there is any difference, place the authorization number in the Remarks section (block 38) along with an explanation of the difference.** This alternate billing method also applies when an authorization has expired.

SPECIAL BILLING PROCEDURES FOR ENROLLEES AGE 21 AND OVER

For eligible enrollees age 21 and over, bill **only** for those limited oral surgery procedures shown as covered in Chapter IV. If uncertain about the coverage of a service, contact the Dental Medicaid office prior to treatment. Services for enrollees age 21 and over require preauthorization unless performed in justified emergency/urgent situations.

For billing **emergency** preauthorized procedures as a claim, request individual consideration, "IC" and attach radiographs and give full details under Remarks in block 38, including the patient's age. Attach operative notes or a summary, if appropriate.

For **non-emergency** preauthorized procedures, file a **request** on the ADA (1994) Claim Form indicating the patient's age and details to substantiate the medical necessity for the service to be performed in block 38 of the form and any necessary attachment/documentation.

Manual Title	Chapter	Page
Dental Manual	V	15
Chapter Subject	Page Revision Date	
Billing Instructions	6-20-2003	

INSTRUCTIONS FOR BILLING MEDICARE COINSURANCE AND DEDUCTIBLE

Medicaid dental coverage is limited to recipients under 21 years of age, except for limited oral surgery. Covered and non-covered oral surgery services for recipients age 21 and older are detailed in Chapter IV.

Virginia Medicaid purchases Medicare Part B coverage for all Medicaid recipients eligible for Medicare benefits and makes payment to providers for Medicare coinsurance and deductible.

The Medicare Program Part B Carriers serving Virginia and the Virginia Medicaid Program have developed a system whereby these carriers will send to Virginia Medicaid the Medicare Explanation of Benefits (EOB) for identified Virginia recipients. This information will be used by the Program to pay Medicare coinsurance and deductible amounts as determined by the carrier. Do not bill Virginia Medicaid directly for services rendered to Medicaid recipients who are also covered by Medicare Program Part B carriers serving Virginia. However, the DMAS-31 adjustment form may be used when needed.

If the Medicare Part B carrier is one of these, bill Medicare directly on the appropriate invoice.

Upon receipt of the Medicare EOB, Virginia Medicaid will process payment automatically to participating providers when the recipient's Medicare number and the provider's Medicare vendor/provider number are in the Medicaid files. Those providers billing Medicare under more than one Medicare vendor/provider number must identify these numbers and names to the Medicaid Program to update its files. Medicare vendor/provider number additions or deletions must also be sent to the Program.

This automatic payment procedure includes Medicaid recipients with Railroad Retirement Medicare benefits.

If problems are encountered, the DMAS-30 (R 6/03) invoice form should be completed, and a copy of the EOB attached and forwarded to:

Virginia Department of Medical Assistance Services
Dental
P. O. Box 27441
Richmond, Virginia 23261-7441

Manual Title	Chapter	Page
Dental Manual	V	16
Chapter Subject	Page Revision Date	
Billing Instructions	6-20-2003	

INSTRUCTIONS FOR COMPLETION OF THE DEPARTMENT OF MEDICAL ASSISTANCE SERVICES (TITLE XVIII) MEDICARE DEDUCTIBLE AND COINSURANCE INVOICE, DMAS-30 (R 6/30)

Purpose To provide a method of billing Medicaid for Medicare deductible and coinsurance. (See the “Exhibits” section at the end of this chapter for a sample form.)

Explanation

Block 1 **Provider Identification Number** - Enter the provider identification number assigned by Medicaid and the provider name and address.

Block 2 **Recipient’s Last Name** - Enter the last name of the recipient.

Block 3 **Recipient’s First Name** - Enter the first name of the recipient.

Block 4 **Recipient Identification Number** - Record the twelve-digit number.

Block 5 **Patient Account Number** - If a provider uses a patient identification number, enter it in this block. This number will appear on the Remittance Voucher preceding the name. Otherwise, leave this block blank.

Block 6 **Recipient HIB Number** (Medicare) - Enter the recipient’s Medicare number.

Block 7 **Primary Carrier Information** (Other Than Medicare) - Check the appropriate block. (Medicare is not the primary carrier in this situation.)

- **Code 2 - No Other Coverage** - If there is not other insurance information identified by the patient or no other insurance provided when the Medicaid eligibility is confirmed, check this block.
- **Code 3 - Billed and Paid** - When a recipient has other coverage that makes a payment which may only satisfy in part the Medicare deductible and coinsurance, check this block and enter the payment in Block 22. If the primary carrier pays as much as the combined totals of the deductible and coinsurance, do not bill Medicaid.
- **Code 5 - Billed and No Coverage** - When other coverage has been billed for the Medicare deductible and coinsurance and

Manual Title	Chapter	Page
Dental Manual	V	17
Chapter Subject	Page Revision Date	
Billing Instructions	6-20-2003	

the service was not covered or the benefits were exhausted, check this block and explain in the Remarks section or attach an Explanation of Benefits (EOB).

- Block 8 **Type Coverage (Medicare)** - Check Block B corresponding to Title XVIII, Part B (outpatient) for which the Program is being billed the deductible and/or coinsurance. NOTE: Always check B only.
- Block 9 **Diagnosis** - Enter the same ICD-9 CM diagnosis code billed to Medicare.
- Block 10 **Place of Treatment** - Enter the appropriate national place of treatment code.
- Block 11 **Accident Indicator** - Check the appropriate box which indicates the reason treatment was rendered:
- Accident** - Possible third party recovery
Emergency - Not an accident
Other - If none of the above
- Patient copay does not apply for treatment immediately following an accident or when treatment was for an emergency situation.
- Block 12 **Type of Service** - Enter the appropriate national code describing the type of service.
- Block 13 **Procedure Code** - Enter the same five-digit procedure code billed to Medicare. Use the CMS code for procedure modifiers if applicable which can be obtained from the American Medical Association *Physicians Current Procedural Terminology* (CPT) book and the Health Care Financing Administration *Common Procedure Coding System* (HCPCS) book.
- Block 14 **Visits/Units Studies** - Enter the units of service which were performed as billed to Medicare.
- Block 15 **Date of Admission** - Leave blank.
- Block 16 **Statement Covers Period** - Enter the beginning and ending dates of service taken from the Medicare Explanation of Benefits (EOMB).
- Block 17 **Charges to Medicare** - Enter the total charges submitted to Medicare.
- Block 18 **Allowed by Medicare** - Enter the amount of the charges allowed

Manual Title	Chapter	Page
Dental Manual	V	18
Chapter Subject	Page Revision Date	
Billing Instructions	6-20-2003	

by Medicare.

Block 19 **Paid by Medicare** - Enter the amount paid by Medicare (taken from the EOMB).

Block 20 **Deductible** - Enter the amount of the deductible (taken from the Medicare EOMB).

Block 21 **Coinsurance** - Enter the amount of the coinsurance (taken from the Medicare EOMB).

Block 22 **Paid by Carrier Other Than Medicare** - If Code 3 is checked in Block 7, enter the payment received from the primary carrier (other than Medicare). (Do not include Medicare payments.)

Block 23 **Patient Pay Amount** - Leave blank.

Signature Signature of the provider or authorized agent and the date signed are required.

**Mechanics
and
Disposition**

Information as explained above may either be typed or legibly handwritten. If an explanation regarding this claim is necessary, the Remarks section may be used. Separate and forward the original copy, along with a copy of the EOMB attached, in the envelope supplied by the Program. Retain the provider's copy in the office files.

The correct address is:

Dental
Virginia Department of Medical Assistance Services
P. O. Box 27441
Richmond, Virginia 23261-7441

Manual Title	Chapter	Page
Dental Manual	V	19
Chapter Subject	Page Revision Date	
Billing Instructions	6-20-2003	

INSTRUCTIONS FOR THE COMPLETION OF THE DEPARTMENT OF MEDICAL ASSISTANCE SERVICES MEDICARE DEDUCTIBLE AND COINSURANCE (TITLE XVIII) ADJUSTMENT INVOICE, DMAS-31 (REVISED 6/96)

Purpose To provide a means of making corrections or changes that have been approved for payment. This form cannot be used for follow-up of denied, rejected, or pended claims. (See “Exhibits” at the end of this chapter for a sample of this form)

Explanation To void the original payment, the information on the adjustment invoice must be identical to the original invoice. To correct the original payment, the adjustment invoice must appear exactly as the original should have.

Block 1 **Adjustment/Void** - Check the appropriate block.

Block 2 **Provider Identification Number** - If not preprinted, enter the number assigned by DMAS.

Block 2A **Reference Number** - Enter the reference number/ICN number taken from the Remittance Voucher for the line of payment needing an adjustment. The adjustment/void cannot be made without this number since it identifies the original invoice.

Block 2B **Reason** - Leave blank.

Block 2C **Input Code** - Leave blank.

Blocks 3 **Recipient’s Name** – Enter the last name and the first name of the patient as it appears on the enrollee’s eligibility card.

Block 4 **Recipient’s Identification Number** - Enter the 12-digit number taken from the enrollee's eligibility card.

Block 5 **Patient Account Number** – Enter the financial account number assigned by the provider. This number will appear on the Remittance voucher after the claim is processed.

Block 6 **Recipient HIB Number (Medicare)** - Enter the enrollee's Medicare number.

Block 7 **Primary Carrier Information (Other Than Medicare)** - Check the appropriate block. (Medicare is not the primary carrier in this situation.)

- **Code 2 - No Other Coverage** –If there is no other insurance information identified by the patient or no other insurance

Manual Title	Chapter	Page
Dental Manual	V	20
Chapter Subject	Page Revision Date	
Billing Instructions	6-20-2003	

provided when the Medicaid eligibility is confirmed, check this block.

- **Code 3 - Billed and Paid** - When an enrollee has other coverage that makes payment which may only satisfy in part the Medicare deductible and coinsurance, check 3 and enter the payment received in Block 19. If the primary carrier pays as much as the combined totals of the deductible and coinsurance, do not bill Medicaid.
- **Code 5 - Billed and No Coverage** - If the enrollee has other sources for the payment of Medicare deductible and coinsurance which were billed and the service was not covered or the benefits had been exhausted, check this block. Explain in the "Remarks" section.

- Block 8 **Type Coverage (Medicare)** - Mark type of coverage "B".
- Block 9 **Diagnosis** - Enter the primary ICD-9-CM diagnosis code, omitting the decimal. Only one code can be processed.
- Block 9A **Place of Treatment** - Enter the appropriate national place of service code:
- Block 10 **Accident Indicator** - Check the appropriate box which indicates the reason the treatment was rendered:
- Accident** - Possible third-party recovery
Emergency - Not an accident
Other - If none of the above
- Block 11 **Type of Service** - Enter the appropriate *national* code describing the type of service:
- Block 11A **Procedure Code** - Enter the 5-digit code which was billed to Medicare. Each procedure must be billed on a separate line. If there is no procedure code billed to Medicare, leave this blank. Use the appropriate national procedure code modifier if applicable
- Block 11B **Visits/Units/Studies** - Enter the units of service performed during the "Statement Covers Period" as billed to Medicare.(Block 13)
- Block 12 **Date of Admission** –Enter the date of admission (if applicable).
- Block 13 **Statement Covers Period** - Using six-digit dates, enter the beginning and ending dates of this service (from) and the last date of this service (thru), e.g., 03-01-03 to 03-31-03.
- Block 14 **Charges to Medicare** - Enter the total charges submitted to Medicare.

Manual Title	Chapter	Page
Dental Manual	V	21
Chapter Subject	Page Revision Date	
Billing Instructions	6-20-2003	

- Block 15 **Allowed by Medicare** - Enter the amount of the charges allowed by Medicare.
- Block 16 **Paid by Medicare** - Enter the amount paid by Medicare (taken from the EOMB).
- Block 17 **Deductible** - Enter the amount of the deductible (taken from the Medicare EOMB).
- Block 18 **Coinsurance** - Enter the amount of the coinsurance (taken from the Medicare EOMB).
- Block 19 **Paid by Carrier Other Than Medicare** - Enter the payment received from the primary carrier (other than Medicare). If Code 3 is marked in Block 7, enter an amount in this block. (Do not include Medicare payments.)
- Block 20 **Patient Pay Amount, LTC Only** - Leave blank.
- Signature** Signature of the provider or the agent and the date signed are required.
- Mechanics and Disposition** The information may be typed or legibly handwritten. Mail the completed claims to:

Department of Medical Assistance Services
Dental
P. O. Box 27444
Richmond, Virginia 23261-7444

Retain a copy for the office files.

REMITTANCE VOUCHER (Payment Voucher)

DMAS sends a Remittance Voucher with each weekly payment made by the Virginia Medical Assistance Program. The remittance voucher is a record of approved, pended, denied, adjusted, or voided claims and should be kept in a permanent file for five (5) years.

The remittance voucher includes an address location, which contains the provider's name and current mailing address as shown in the DMAS' provider enrollment file. In the event of a change-of-address, the U.S. Postal Service will not forward Virginia Medicaid payment checks and vouchers to another address. Therefore, it is recommended that DMAS' Provider Enrollment and Certification Unit be notified in sufficient time prior to a change-of-address in order for the provider files to be updated.

Providers are encouraged to monitor the remittance vouchers for special messages since they serve as notifications of matters of concern, interest and information. For example,

Manual Title	Chapter	Page
Dental Manual	V	22
Chapter Subject	Page Revision Date	
Billing Instructions	6-20-2003	

such messages may relate to upcoming changes to Virginia Medicaid policies and procedures; may serve as clarification of concerns expressed by the provider community in general; or may alert providers to problems encountered with the automated claims processing and payment system.

ANSI X12N 835 HEALTH CARE CLAIM PAYMENT ADVICE

The Health Insurance Portability and Accountability Act (HIPAA) requires that Medicaid comply with the EDI standards for health care as established by the Secretary of Health and Human Services. The 835 Claims Payment Advice transaction set is used to communicate the results of claim adjudication. DMAS will make a payment with an electronic funds transfer (EFT) or check for a claim that has been submitted by a provider (typically by using an 837 Health Care Claim Transaction Set). The payment detail is electronically posted to the provider's accounts receivable using the 835. In addition to the 835 the provider will receive an unsolicited 277 Claims Status Response for the notification of pending claims. For technical assistance with certification of the 835 Claim Payment Advice please contact our fiscal agent, First Health, at (888)-829-5373 and choose Option 2 (EDI).

CLAIM INQUIRIES

Inquiries concerning covered benefits, specific billing procedures, or questions regarding Virginia Medicaid policies and procedures should be directed to:

Customer Services
Department of Medical Assistance Services
600 East Broad Street, Suite 1300
Richmond, VA 23219

Telephone Numbers:

1-804-786-6273	Richmond Area and out-of-state long distance
1-800-552-8627	In-state long distance (toll-free)

Claims Status and Enrollee verification may be obtained by telephoning:

1-800-772-9996	Toll-free throughout the United States
1-800-884-9730	Toll-free throughout the United States
(804) 965-9732	Richmond and Surrounding Counties
(804) 965-9733	Richmond and Surrounding Counties

Manual Title	Chapter	Page
Dental Manual	V	23
Chapter Subject	Page Revision Date	
Billing Instructions	6-20-2003	

EXHIBITS

EXHIBITS TABLE OF CONTENTS

ADA (1994) Claim Form, J504	1
Title XVIII (Medicare) Deductible and Coinsurance Invoice (DMAS-30 R 6/03)	2
Claim Attachment Form (DMAS-3)	4
Title XVIII (Medicare) Deductible and Coinsurance Invoice – Adjustment (DMAS 31-R 6/96)	6

See reverse for instructions

1. Dental claim Form <input type="checkbox"/> Dentist's pre-treatment estimate <input type="checkbox"/> Dentist's statement of actual services Provider ID #		2. <input type="checkbox"/> Medicaid Claim <input type="checkbox"/> EPSDT Prior Authorization # Patient ID #		3. Carrier name and address																					
P A T I E N T C O V E R A G E I N F O R M A T I O N	4. Patient name first _____ m. _____ last _____		5. Relationship to employee <input type="checkbox"/> self <input type="checkbox"/> child <input type="checkbox"/> spouse <input type="checkbox"/> other _____		6. Sex m f	7. Patient birthdate MM DD YYYY	8. If full time student school _____ city _____																		
	9. Employee/subscriber name and mailing address		10. Employee/subscriber dental plan I.D. number	11. Employee/subscriber birthdate MM DD YYYY	12. Employer (company) name and address		13. Group number																		
	14. Is patient covered by another dental plan yes no If yes, complete 15-a. Is patient covered by a medical plan? yes no	15-a. Name and address of carrier(s)		15-b. Group no.(s)		16. Name and address of other employer(s)																			
	17-a. Employee/subscriber name (if different from patient's)		17-b. Employee/subscriber dental plan I.D. number	17-c. Employee/subscriber birthdate MM DD YYYY		18. Relationship to patient <input type="checkbox"/> self <input type="checkbox"/> parent <input type="checkbox"/> spouse <input type="checkbox"/> other _____																			
19. I have reviewed the following treatment plan and fees. I agree to be responsible for all charges for dental services and materials not paid by my dental benefit plan, unless the treating dentist or dental practice has a contractual agreement with my plan prohibiting all or a portion of such charges. To the extent permitted under applicable law, I authorize release of any information relating to this claim.						20. I hereby authorize payment of the dental benefits otherwise payable to me directly to the below named dental entity.																			
Signed (Patient* – see reverse) _____ Date _____						Signed (Employee/subscriber) _____ Date _____																			
B I L L I N G D E N T I S T	21. Name of Billing Dentist or Dental Entity					30. Is treatment result of occupational illness or injury? No Yes If yes, enter brief description and dates																			
	22. Address where payment should be remitted					31. Is treatment result of auto accident?																			
	23. City, State, Zip					32. Other accident?																			
	24. Dentist Soc. Sec. or T.I.N. (see reverse*)		25. Dentist license no.		26. Dentist phone no.		33. If prosthesis, is this initial placement?		(If no, reason for replacement)		34. Date of prior placement														
	27. First visit date current series	28. Place of treatment Office Hosp. ECF Other	29. Radiographs or models enclosed?	No Yes How many?	35. Is treatment for orthodontics?		If service already commenced enter:		Date appliances placed		Mos. treatment remaining														
36. Identify missing teeth with "x"													37. Examination and treatment plan – List in order from tooth no. 1 through tooth no. 32 – Using charting system shown.												
													Tooth # or letter	Surface	Description of service (including x-rays, prophylaxis, materials used, etc.)	Date service performed			Procedure number	Fee	For administrative use only				
													Mo.	Day	Year										
38. Remarks for unusual services																									
39. I hereby certify that the procedures as indicated by date have been completed and that the fees submitted are the actual fees I have charged and intend to collect for those procedures.													41. Total Fee Charged												
Signed (Treating Dentist) _____ License Number _____ Date _____													42. Payment by other plan												
40. Address where treatment was performed City _____ State _____ Zip _____													Max. Allowable												
													Deductible												
													Carrier %												
													Carrier pays												
													Patient pays												

©American Dental Association, 1994
J504 (Same as ADA Dental Claim Form - J510, J511, J512)

TITLE XVIII (MEDICARE) DEDUCTIBLE AND COINSURANCE INVOICE

VIRGINIA

DEPARTMENT OF MEDICAL ASSISTANCE SERVICES

01 Provider's Medicaid ID Number				02 Last Name				03 First Name			
04 Recipient ID Number				05 Patient's Account Number				06 Recipient's HIB Number (Medicare)			

1		07 Primary Carrier Information Other Than Medicare <input type="checkbox"/> 3 Billed and Paid <input type="checkbox"/> 5 Billed No Coverage		08 Type Of Coverage Medicare <input type="checkbox"/> A <input type="checkbox"/> B		09 Diagnosis		10 Place of Treatment		11 Accident / Emer Ind <input type="checkbox"/> ACC <input type="checkbox"/> Emer <input type="checkbox"/> Other		12 Type of Service		13 Procedure Code		14 Visits/Units, Studies	
15 Date of Admission MM DD YY		From MM DD YY		16 Statement Covers Period MM DD YY		Thru MM DD YY		17 Charges to Medicare		18 Allowed By Medicare		19 Paid By Medicare					
20 Deductible		21 Co-Insurance		22 Paid By Carrier Other Than Medicare		23 Pat Pay Amt. LTC Only											

2		07 Primary Carrier Information Other Than Medicare <input type="checkbox"/> 3 Billed and Paid <input type="checkbox"/> 5 Billed No Coverage		08 Type Of Coverage Medicare <input type="checkbox"/> A <input type="checkbox"/> B		09 Diagnosis		10 Place of Treatment		11 Accident / Emer Ind <input type="checkbox"/> ACC <input type="checkbox"/> Emer <input type="checkbox"/> Other		12 Type of Service		13 Procedure Code		14 Visits/Units, Studies	
15 Date of Admission MM DD YY		From MM DD YY		16 Statement Covers Period MM DD YY		Thru MM DD YY		17 Charges to Medicare		18 Allowed By Medicare		19 Paid By Medicare					
20 Deductible		21 Co-Insurance		22 Paid By Carrier Other Than Medicare		23 Pat Pay Amt. LTC Only											

3		07 Primary Carrier Information Other Than Medicare <input type="checkbox"/> 3 Billed and Paid <input type="checkbox"/> 5 Billed No Coverage		08 Type Of Coverage Medicare <input type="checkbox"/> A <input type="checkbox"/> B		09 Diagnosis		10 Place of Treatment		11 Accident / Emer Ind <input type="checkbox"/> ACC <input type="checkbox"/> Emer <input type="checkbox"/> Other		12 Type of Service		13 Procedure Code		14 Visits/Units, Studies	
15 Date of Admission MM DD YY		From MM DD YY		16 Statement Covers Period MM DD YY		Thru MM DD YY		17 Charges to Medicare		18 Allowed By Medicare		19 Paid By Medicare					
20 Deductible		21 Co-Insurance		22 Paid By Carrier Other Than Medicare		23 Pat Pay Amt. LTC Only											

4		07 Primary Carrier Information Other Than Medicare <input type="checkbox"/> 3 Billed and Paid <input type="checkbox"/> 5 Billed No Coverage		08 Type Of Coverage Medicare <input type="checkbox"/> A <input type="checkbox"/> B		09 Diagnosis		10 Place of Treatment		11 Accident / Emer Ind <input type="checkbox"/> ACC <input type="checkbox"/> Emer <input type="checkbox"/> Other		12 Type of Service		13 Procedure Code		14 Visits/Units, Studies	
15 Date of Admission MM DD YY		From MM DD YY		16 Statement Covers Period MM DD YY		Thru MM DD YY		17 Charges to Medicare		18 Allowed By Medicare		19 Paid By Medicare					
20 Deductible		21 Co-Insurance		22 Paid By Carrier Other Than Medicare		23 Pat Pay Amt. LTC Only											

24 Remarks																	
------------	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

THIS IS TO CERTIFY THAT THE FOREGOING INFORMATION IS TRUE, ACCURATE AND COMPLETE. I UNDERSTAND THAT PAYMENT AND SATISFACTION OF THIS CLAIM WILL BE FROM FEDERAL AND STATE FUNDS, AND THAT ANY FALSE CLAIMS, STATEMENTS OR DOCUMENTS, OR CONCEALMENT OF A MATERIAL FACT, MAY BE PROSECUTED UNDER APPLICABLE FEDERAL OR STATE LAWS.

SIGNATURE

DATE

Instructions for the Completion of the Department of Medical Assistance Services (Title XVIII) Medicare Deductible and Coinsurance Invoice, DMAS-30 – R 6/03

Purpose: To provide a method of billing Virginia Medicaid for Medicare deductible and coinsurance.

NOTE: This form can be used for four different procedures **per** Medicaid recipient. A different form must be used for **each** Medicaid enrollee.

- Block 01** **Provider's Medicaid ID Number** – Enter the 9-digit Virginia Medicaid provider identification number assigned by Virginia Medicaid.
- Block 02** **Recipient's Last Name** – Enter the last name of the patient as it appears from the enrollee's eligibility verification.
- Block 03** **Recipient's First Name** – Enter the first name of the patient as it appears from the enrollee's eligibility verification.
- Block 04** **Recipient ID Number** – Enter the 12-digit number taken from the enrollee's eligibility card.
- Block 05** **Patient's Account Number** – Enter the financial account number assigned by the provider. This number will appear on the Remittance Voucher after the claim is processed.
- Block 06** **Recipient's HIB Number (Medicare)** – Enter the enrollee's Medicare number.
- Block 07** **Primary Carrier Information (Other Than Medicare)** – Check the appropriate block. (Medicare is not the primary carrier in this situation.)
- **Code 2 – No Other Coverage** – If there is not other insurance information identified by the patient or no other insurance provided when the Medicaid eligibility is confirmed, check this block.
 - **Code 3 – Billed and Paid** – When an enrollee has other coverage that makes a payment which may only satisfy in part the Medicare deductible and coinsurance, check this block and enter the payment in Block 22. If the primary carrier pays as much as the combined totals of the deductible and coinsurance, do not bill Medicaid.
 - **Code 5 – Billed and No Coverage** – If the enrollee has other sources for the payment of Medicare deductible and coinsurance which were billed and the service was not covered or the benefits had been exhausted, check this block. Explain in the "Remarks" section.
- Block 08** **Type of Coverage (Medicare)** – Mark the appropriate type of Medicare coverage.
- Block 09** **Diagnosis** – Enter the principal ICD-9-CM diagnosis code, omitting the decimal. Only one diagnosis code can be entered and processed.
- Block 10** **Place of Treatment** – Enter the appropriate national place of service code.
- Block 11** **Accident/Emergency Indicator** – Check the appropriate box, which indicates the reason the treatment, was rendered:
- **ACC** – Accident, Possible third-party recovery
 - **Emer** – Emergency, Not an accident
 - **Other** – If none of the above
- Block 12** **Type of Service** – Enter the appropriate national code describing the type of service.
- Block 13** **Procedure Code** – Enter the 5-digit CPT/HCPCS code that was billed to Medicare. Each procedure must be billed on a separate line. If there was no procedure code billed to Medicare, leave this block blank. Use the appropriate national procedure code modifier if applicable.
- Block 14** **Visits/Units/Studies** – Enter the units of service performed during the "Statement Covers Period" (block 16) as billed to Medicare.
- Block 15** **Date of Admission** – Enter the date of admission
- Block 16** **Statement Covers Period** – Using six-digit dates, enter the beginning and ending dates of this service (from) and the last date of this service (thru) (e.g., 03-01-03 to 03-31-03).
- Block 17** **Charges to Medicare** – Enter the total charges submitted to Medicare.
- Block 18** **Allowed by Medicare** – Enter the amount of the charges allowed by Medicare.
- Block 19** **Paid by Medicare** – Enter the amount paid by Medicare (taken from the Medicare EOMB).
- Block 20** **Deductible** – Enter the amount of the deductible (taken from the Medicare EOMB).
- Block 21** **Co-insurance** – Enter the amount of the co-insurance (taken from the Medicare EOMB).
- Block 22** **Paid by Carrier Other Than Medicare** – Enter the payment received from the primary carrier (other than Medicare). If the Code 3 is marked in Block 7, enter an amount in this block. (Do not include Medicare payments).
- Block 23** **Patient Pay Amount, LTC Only** – Enter the patient pay amount, if applicable.
- Block 24** **Remarks** – If an explanation regarding this claim is necessary, the "Remarks" section may be used. Submit only original claim forms and attach a copy of the EOMB to the claim.
- Signature** Note the certification statement on the claim form, then sign and date the claim form.

VIRGINIA DEPARTMENT OF MEDICAL ASSISTANCE SERVICES

CLAIM ATTACHMENT FORM

Attachment Control Number (ACN) :

--	--	--	--	--

Patient Account Number (20 positions limit) M M D D C C Y Y Sequence
Number (5 digits)

Date of Service

***Patient Account Number should consist of numbers and letters only. NO spaces, dashes, slashes or special characters.**

Provider Number:	Provider Name:
-------------------------	-----------------------

Enrollee Identification Number:
--

Enrollee Last Name:	First:	MI:
----------------------------	---------------	------------

<input type="checkbox"/> Paper Attached	<input type="checkbox"/> Photo(s) Attached	<input type="checkbox"/> X-Ray(s) Attached
<input type="checkbox"/> Other (specify) _____		

COMMENTS: _____ _____ _____ _____ _____ _____

THIS IS TO CERTIFY THAT THE FOREGOING AND ATTACHED INFORMATION IS TRUE, ACCURATE AND COMPLETE. ANY FALSE CLAIMS, STATEMENTS, DOCUMENTS, OR CONCEALMENT OF A MATERIAL FACT MAY BE PROSECUTED UNDER APPLICABLE FEDERAL OR STATE LAWS.

Authorized Signature _____ **Date Signed** _____

Mailing addresses are available in the Provider manuals or check DMAS website at www.dmas.state.va.us. Attachments are sent to the same mailing address used for claim submission. Use appropriate PO Box number.

INSTRUCTIONS FOR THE COMPLETION OF THE DMAS-3 FORM. THE DMAS-3 FORM IS TO BE USED BY EDI BILLERS ONLY TO SUBMIT A NON-ELECTRONIC ATTACHMENT TO AN ELECTRONIC CLAIM.

Attachment Control Number (ACN) should be indicated on the electronic claim submitted. The ACN is the combined fields 1, 2 and 3 below. (i.e. Patient Account number is 123456789. Date of service is 07/01/2003. Sequence number is 12345. The ACN entered on the claim should be 1234567890701200312345.)

IMPORTANT: THE ACN ON THE DMAS-3 FORM MUST MATCH THE ACN ON THE CLAIM OR THE ATTACHMENT WILL NOT MATCH THE CLAIM SUBMITTED. IF NO MATCH IS FOUND, CLAIM MAY BE DENIED. ATTACHMENTS MUST BE SUBMITTED AND ENTERED INTO THE SYSTEM WITHIN 21 DAYS OR THE CLAIM MAY RESULT IN A DENIAL.

1. **Patient Account Number** – Enter the patient account number up to 20 digits. Numbers and letters only should be entered in this field. **Do not** enter spaces, dashes or slashes or any special characters.
2. **Date of Service** – Enter the from date of service the attachment applies to.
3. **Sequence Number** – Enter the provider generated sequence number up to 5 digits only.
4. **Provider Number** – Enter the Medicaid Provider number.
5. **Provider Name** – Enter the name of the Provider.
6. **Enrollee Identification Number** – Enter the Medicaid ID number of the Enrollee.
7. **Enrollee Last Name** - Enter the last name of the Enrollee.
8. **First** – Enter the first name of the Enrollee.
9. **MI** – Enter the middle initial of the Enrollee.
10. **Type of Attachment** – Check the type of attachment or specify.
11. **Comment** – Enter comments if necessary.
12. **Authorized Signature** – Signature of the Provider or authorized Agent.
13. **Date Signed** – Enter the date the form was signed.

Attachments are sent to the same mailing address used for claim submission. Use appropriate PO Box number. Mailing addresses are available in the Provider manuals or check the DMAS website at www.dmas.state.va.us.

TITLE XVIII (MEDICARE) DEDUCTIBLE AND COINSURANCE INVOICE

VIRGINIA

DEPARTMENT OF MEDICAL ASSISTANCE SERVICES

1. ADJUSTMENT 092		VOID 094		2. PROVIDER ID. NO. (7)		A. REFERENCE NUMBER (9)		B. REASON		C. INPUT CODE	
3. RECIPIENT'S LAST NAME			FIRST NAME			4. RECIPIENT'S ID. NUMBER (12)			5. PATIENT ACCOUNT NUMBER		
6. RECIPIENT'S HIB NUMBER (MEDICARE)			7. PRIMARY CARRIER INFORMATION OTHER THAN (MEDICARE)			8. TYPE COVERAGE (MEDICARE)			9. DIAGNOSIS		
10. PLACE OF TREAT			11. ACCIDENT/EMERGENCY INDICATOR			12. TYPE SERV			13. PROCEDURE CODE (5)		
14. VISITS/UNITS (2)			15. DATE OF ADMISSION			16. STATEMENT COVERS PERIOD			17. FROM		
18. THRU			19. PAID BY CARRIER OTHER THAN MEDICARE			20. PATIENT PAY AMOUNT LTC ONLY			21. CHARGES TO MEDICARE		
22. ALLOWED BY MEDICARE			23. PAID BY MEDICARE			24. DEDUCTIBLE			25. COINSURANCE		

DATE OF REMITTANCE VOUCHER CLAIM WAS APPROVED

THIS FORM IS FOR CHANGING OR VOIDING A PAID ITEM. THE CORRECT REFERENCE NUMBER OF THE PAID CLAIM AS SHOWN ON THE REMITTANCE VOUCHER IS ALWAYS REQUIRED.

REMARKS:

THIS IS TO CERTIFY THAT THE FOREGOING INFORMATION IS TRUE, ACCURATE AND COMPLETE. I UNDERSTAND THAT PAYMENT AND SATISFACTION OF THIS CLAIM WILL BE FROM FEDERAL AND STATE FUNDS, AND THAT ANY FALSE CLAIMS, STATEMENTS, OR DOCUMENTS OR CONCEALMENT OF A MATERIAL FACT, MAY BE PROSECUTED UNDER APPLICABLE FEDERAL OR STATE LAWS.

ORIGINAL COPY

SIGNATURE

DATE